Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DAVID WEST DO
3100 TIMMONS LANE
HOUSTON, TX 77027

Respondent Name
TEXAS MUTUAL INSRUANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-11-1772-01

MFDR Date Received
February 2, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier refuses to pay total amount due even after a request for reconsideration was sent."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor was asked to determine impairment rating as a designated doctor…The requestor conducted impairment rating (IR) exams on 5/21/10 to the lumbar spine, cervical spine, the right shoulder and the right wrist…The requestor was paid $350.00 inadvertently for an MMI exam. The requestor was paid $150.00 only for a lumbar impairment by the DRE. The total paid amount under numbers 2 and 3 is $500.00. The PLN-11 of 9/8/9 indicates the compensable injury is to the lumbar and cervical spines only…Therefore, requestor is due payment for the cervical impairment by the DRE, which is $150.00. The requestor is due no payment for rating the right shoulder and right wrist. The lumbar spine was assessed and paid $150.00 Payment for the cervical spine assessment can be credited through the $350.00 paid for the MMI exam. This means Texas Mutual is due a refund of the $200.00."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 21, 2010	99456-W5-WP	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for the reimbursement of workers' compensation specific services rendered on or after March 1, 2008.

3. 28 Texas Administrative Code § 130.6 sets out the procedures for Designated Doctor Examination for Maximum Medical Improvement and/or Impairment Ratings.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 24, 2010
   - CAC – W1 – Workers Compensation State Fee Schedule Adjustment.
   - 790 – This charge was reimbursed in accordance

   Explanation of benefits dated July 14, 2010
   - CAC – W1– Workers Compensation State Fee Schedule Adjustment.
   - CAC – W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - 891 – No additional payment after reconsideration.

Issues

1. What are the billing guidelines for an Impairment Rating exam?
2. Is the requestor entitled to reimbursement for the Maximum Medical Improvement (MMI) exam?
3. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
4. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (i)(A) states," Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier 'W5' is the first modifier to be applied when performed by a designated doctor."

   28 Texas Administrative Code §134.204 (j)(4) states, " The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.

   28 Texas Administrative Code §134.204 (j)(4)(C)(i) states, "For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal boy areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities(including feet.)"

   28 Texas Administrative Code §134.204 (j)(4)(C)(i)(ii) states, The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body are if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) If full physical evaluation, with range of motion is performed; (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area.
2. Review of the requestor's submitted medical records finds a copy of the disputed bill for CPT Code 99456-W5-WP (2 units), copy of a Request for a Designated Doctor (DWC032) and an EES-14 form. The EES-14 sent by the Division indicates that the purpose of the exam is to determine the impairment rating of the injured employee. Review of the requestor's medical records supports that a Maximum Medical Improvement/Impairment Rating (MMI/IR) exam was completed and MMI/IR was assigned. However, the Division ordered an impairment rating exam only. Therefore, reimbursement is not recommended for the MMI portion of the exam.
3. Review of the Designated Doctor Evaluation narrative submitted supports the rating of the lumbar/cervical spine (spine) and right shoulder/wrist (upper extremities) using the Range of Motion (ROM) method per the AMA Guides to the Evaluation of Permanent Impairment, 4th Edition in accordance with 28 Texas Administrative Code § 134.204(j)(4)(C)(ii)(II). . Per 28 Texas Administrative Code § 134.204(j)(4)(C)(ii)(II)(a), the MAR for the 1st musculoskeletal area IR using Range of Motion (ROM) on the lumbar/cervical spine (spine) is $300.00.

   Per the PLN-11, Notice of Disputed Issues(s) and Refusal to Pay Benefits, dated September 8, 2009, 'Texas Mutual Insurance Company has accepted a lumbar and cervical strain only.' 28 Texas Administrative Code § 130.6 (3) states, 'When the impairment rating is the only issue in question, the doctor shall assign an impairment rating based on the employee's medical condition on the MMI date." 28 Texas Administrative Code § 130.6 (5) states, "When the extent of injury may not be agreed upon by the parties (based upon documentation provided by the treating doctor and/or insurance carrier or the comments of the employee regarding his/her injury), the designated doctor shall provide multiple certifications of MMI and impairment ratings that take into account the various interpretations of the extent of injury so that when the Division resolves the dispute, there is already an applicable certification of MMI and impairment rating from which to pay benefits as required by the Act." Therefore, per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(b), the MAR for the 2nd musculoskeletal area, Range of Motion (ROM) on the right shoulder/wrist (upper

extremities) is $150.00. Although the requestor used the ROM method to determine impairment rating for 1st and 2nd musculoskeletal areas, the narrative indicates that the requestor gives a DRE Category II upon assignment of the whole person Impairment. Therefore, the MAR for each musculoskeletal area is $150.

The combined MAR for the impairment ratings on the lumbar/cervical spine (spine) and the right shoulder/wrist is $300.

4. The respondent has previously reimbursed the amount of $500.00 for the disputed CPT Code 99456-W5-WP. Therefore the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 8, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.